Group Psychotherapy for Criminal Offenders

A Program for Parolees Under Social-Psychological Coercion

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• **Selected prisoners, most of them with severe character disorders, are permitted to serve the remaining portion of their sentence on parole in the community on condition that they be patients in psychotherapy at a psychiatric clinic created in 1953 for this purpose. Nearly all the patients begin without personal motivation for such treatment. Attendance has been attained because parole officers are assigned to the task of enforcing attendance.**

Coercion can bring these reluctant patients to expose themselves to treatment, but staff members then have the task to overcome hostility, combat extensive rationalizations, and transform an initially poor rapport into patient participation in working through major personality change.

This clinic provides an interesting laboratory for the development of a psychiatric treatment program for adults who have not responded well to a great variety of forms of correctional care.

THIS presentation describes the treatment program of a state psychiatric clinic for the outpatient psychotherapy of adult male criminal offenders after their release from prison. The clinic's patients are coerced into attending by the fear that their freedom will be taken from them by return to prison if they do not.

Psychotherapy in such circumstances poses a number of questions. As a purely practical matter, will these patients keep their appointments—will they be physically present for the psychotherapeutic relationship? In this coercive atmosphere, will the psychotherapeutic process produce enough change to be worthy of the name, or will treatment be merely simulated, a going through the motions? Is the psychotherapist morally justified in attempting to force changes in the mind upon these unwilling nonpsychotic persons, or is this a violation by the state of basic human rights—a kind of brainwashing? Is the expenditure of public funds for a psychiatric clinic of "captive" patients appropriate while mental hygiene clinics, due to insufficient funds, have long waiting lists of persons anxious to be patients?

BACKGROUND

The magnitude and repetitive nature of criminal behavior are fundamental factors in the rationale of the program. In the American population more than two and a quarter million persons annually commit known serious offenses.[3] Four out of five men committed to California prisons during 1955 have records of previous correctional confinement.[1] In this state's prison system (organized since 1945 into the Department of Corrections) the majority of recidivistic criminal offenders are viewed as not only socially deviant; they are also regarded as mentally abnormal.[5] Much interest exists in the development of a comprehensive program to effect changes in the personality of the offenders, in addition to controlling them for the protection of potential victims.

A crucial administrative consideration is the fact that almost all of these offenders will be released from prison. There are a number of factors which combine to bring about this situation:

¶Prolonged imprisonment, while protective of the community, is believed to serve no useful purpose for most prisoners. It is generally regarded as traumatic for a human being to be so restricted in freedom, emotionally isolated from the family, and sexually deprived. Certain offenders who will not commit further offenses after release cannot be distinguished at high levels of predictive confidence from the potential recidivists. And it is expensive to keep offenders in institutions continuously and indefinitely. An enlightened society prefers not to lock people up forever.

¶The indeterminate sentence, functioning in California since 1917, provides for release on the principle of fitting the sentence to the personality of the criminal, not only to his crime. Nearly all offenders are committed under this law to the Department of Corrections for an indeterminate period, such as one year to life. A determinate sentence is set later by a board, the Adult Authority. This board has been described as making decisions both on the basis of its judicial powers, considering the seriousness of the offense, and also on clinical considerations, evaluating past psychological development and current personality functioning.[2]

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¶Parole facilitates release of prisoners. Supervision of offenders after release from prison is an instrument for the protection of the community by intervention whenever the offender is recognized to be regressing antisocially, and for assistance to the offender in his transition from controlled institutional living to freedom in society.

All of this means that most prisoners, including the many who have committed aggressive antisocial depredations upon the person and property of victims, will return into the community after several years of institutionalization. In the light of statistics on recidivism, these persons are sufficiently dangerous that the public has no choice but to act decisively if it is to have any reasonably safe program other than lifetime imprisonment.

The Department of Corrections and the public look to psychiatry, with its body of knowledge of character development and motivations for behavior and its psychotherapeutic skill, to join with correctional personnel in the development of a program of necessary action. If psychiatry as a profession does not meet these expectations, California's correctional program will not resign its efforts to develop a program aimed at personality change; it will be limited to the methods of allied fields.

THE EMERGENCE OF AN OUTPATIENT CLINIC

In July of 1950 the Department of Corrections created a hospital for its prison system, the California Medical Facility (CMF). Psychiatrists were appointed to the positions of Superintendent and Clinical Director and were provided with a psychiatric team consisting of social workers, clinical psychologists and psychiatrists, including the senior author. Within a short time, the Clinical Director had organized most of the inmate population into therapy groups.[8]* Currently, 11 therapists treat the majority of the inmates of the Medical Facility, about 1,100 men, in psychotherapy groups throughout their institutional stay. Most groups range from six to twelve members and meet twice weekly.†

Psychiatric personnel in mental hygiene clinics and in private medical practice have tried to treat criminal offenders after their release from prison. There have been many unsatisfactory experiences with this group of patients during the periods these offenders are in the community. Most psychiatrists avoid accepting such persons for psychotherapy, or limit themselves to a few for training or research purposes.

Among the factors which have combined to bring about this rejection are absenteeism of these patients from scheduled appointments and the unrewarding nature of the treatment experience for both the patient and the therapist. In his usual practice a therapist derives satisfaction from helping the patient master immaturity and irrationality, and obtains gratifications from close relationship with stimulating personalities. But psychotherapeutic work with prisoners on parole is largely barren of these psychic compensations. It is often uneconomic for the clinician, in time, in energies and in fees collected, to treat such patients over a long term. Many patients repeatedly neglect to appear for appointments, and the time then is eventually offered to numerous psychoneurotic and psychotic patients more desirous of help who are waiting to take the place of the absent, inadequately motivated parolees. The net result is that, for all practical purposes, psychiatric facilities of the community do not treat parolees.

Creation of a state psychiatric clinic for paroled criminal offenders provides, in the community, a program analogous to the California Medical Facility's treatment program for offenders during their imprisonment. The clinic's present staff consists of a psychiatrist (the senior author)* and three clinical psychologists. A psychoanalyst consults biweekly.

THE TREATMENT PROGRAM

The patient is virtually forced to keep appointments at the clinic: The Adult Authority permits the prisoner to serve the remainder of his sentence in the community only on condition that he participate in psychotherapy at the clinic. Parole officers are assigned the task of enforcing attendance and they use the implicit or explicit threat of return to prison. Within this legal-administrative structure, the psychotherapists endeavor to develop a treatment situation. The Adult Authority facilitates this effort by providing for protection of the confidential nature of the patient-therapist relationship. When problems arise concerning the privacy of information given by the patient in the clinic, the final decision as to whether it can be made available to any other agency or person is vested in the psychiatrist. The Department of Corrections thus has provided psychiatry a

*The consultant psychoanalyst has reported upon clinical aspects of this program.[7]

†At present about 10 per cent of the approximately 16,000 persons confined in prisons in California are transferred to the Medical Facility and receive psychiatric treatment there. Several of the state prisons have psychiatric staffs engaged in treatment. Efforts at achieving personality changes are not confined, of course, to psychotherapy. Custodial and other correctional personnel are endeavoring, for example, to establish relationships with criminal offenders in small group settings in an introspective atmosphere. In 1954 the Deputy Director of the Department of Corrections personally initiated this group counseling program at the Folsom State Prison, and subsequently at other prisons throughout the State.[4] Sometimes the counselors obtain consultation from members of the psychiatric team. More than 7,000 criminal offenders, approximately half of all persons confined in California prisons, are currently members of these weekly counseling groups. A less intensive group meeting program is also being developed by parole officers for men after release from prison.

*He resigned from the Department of Correction, November 1, 1957.

genuine opportunity to perform this clinical experiment in keeping with its professional standards.

During the four years of the clinic's existence, over a thousand men have been referred and evaluated; one third of this number have been accepted as patients and treated. Almost 90 per cent of the patients are diagnosed as having personality disorders. About 10 per cent are diagnosed as psychotic and as having brain damage. Psychoneurotic persons, who are most amenable to psychotherapy and who constitute the bulk of patients generally selected for psychiatric treatment in outpatient settings, comprise 2 per cent of the patient load. Irrespective of diagnostic categories, the degree of impairment is diagnosed as severe in 90 per cent of all patients.

At present there are 160 patients being treated in 24 psychotherapy groups averaging seven members per group. Group sessions are 60 to 90 minutes in duration and they are held once or twice weekly. A few patients are treated in individual psychotherapy in addition to group psychotherapy; and a few receive individual therapy only, either because they are too disturbed to be treated in an outpatient group setting or there is no appropriate group for their psychiatric needs.

THE PROCESS OF PSYCHOTHERAPY

Patients at this clinic are, for all practical purposes, unmotivated for psychotherapy. It is the staff's experience that virtually all the patients enter into an initial prolonged negative transference situation. Resistances are pronounced, hostilities aggressively displayed, rapport poor. Verbalization is devoted to everyday trivia; there is virtually no introspection nor association of early biographical events. Denial, projection and a wide variety of rationalizations are extensively employed.*

Usually for a long time the therapist reports he can do little more than repetitively offer the simplest of interpretations and reflect back patient hostilities. Questions are frequently asked of the therapist in apparent receptive passivity. Yet, whenever the therapist complies even minimally, reactions are typically resentful. Often, it is as if the patient's passivity becomes replaced by his aggressive strivings for independence. Until the patient reaches the point of actively trying to help himself, with the therapist's and the group's assistance, interpretations seem to fail to reach him emotionally. They appear to be warded off effectively by resistances. Progress in basic personality change is very slow. Then, as therapy has its impact over the long term, anxiety and limited motivation develop. Positive transference features appear. There is a late appearance of observing ego and of the patient's recognition and eventual acknowledgment of some of his own role in his problems. His verbalizations become less exclusively projections, rationalizations and trivia. He becomes introspective and gradually reveals biographical material.

Thus a relationship begun under coercion usually becomes somewhat therapeutic. However in almost all cases there is doubt about the extent of the personality changes. The clinic has now been in existence long enough to make possible a statistical analysis of recorded data on recidivism of its patients. But even without such a study, the job of treating such severe character disorders so late is often looked upon by the staff as more than can be met by the capacity of the clinic's present program.† There is too much case by case evidence that many of the patients fail to acquire the inner controls they need to protect society and themselves from the risk of breakthrough of their aggressive and immature impulses in antisocial directions. Even when psychological changes occur, they are often too limited to result in changes in ways of life sufficient to reduce the probability of antisocial reaction to the same kinds of environmental pressures which were associated with previous criminal behavior.

Most of the patients at the clinic do much searching for an acceptable excuse in their efforts to evade clinic appointments. They try to manipulate their parole officers and their therapists to function at cross purposes. Many denounce the clinic and parole office personnel to one another. Frequently they attempt to form a "friend without influence" relationship both with parole officers and therapists.

In the interaction of psychotherapists and parole officers, both working with the same prisoners, a paradoxical role reversal exists: Parole officers have often been stereotyped as punitive, psychotherapists as permissive, supportive, and understanding. Actually we find that the criminal offender experiences these roles as exchanged. The parole officer is a "practical" friend. He assists in location of jobs, in finding places to live and in provision of meal tickets and lodging tickets when the parolee is unemployed. The parole officer, influenced by a social work philosophy, endeavors to establish, maintain and nurture rapport. In this effort, many parole officers tend to

*The experiences at the clinic closely parallel Redl's.[6] The staff has encountered a large number of stereotyped rationalizations and other defenses frequently verbatim of those reported. As it has been put so well: "[delinquent] behavior is not harder to read than that of a neurotic; it is only more difficult to bear." Among the numerous defenses described by Redl are: "expertness in manipulation," "organized defamation," and "friend without influence," designating the latter as one of the most difficult problems that exist in the training of teachers, group leaders and personnel in correctional supervision.

†The presumption that insufficient success in treatment of these patients may be because "too little is given too late" is quite common with regard to mental health services which usually have fewer resources than is deemed desirable by the persons responsible for their administration.

be accepting, understanding, supportive and giving, within the limits of the supervisory framework.

Upon the context of this ideology a psychiatric clinic is superimposed. The parole officer has a therapeutically subsidiary status insofar as he is assigned the task of enforcing parolee attendance. This places the parole officer in a position in which he is expected to exert pressure to overcome what the clinic staff regards as patient resistance to attendance at the therapy session, even when resistance is realistically grounded on the excuse that attending interferes with employment opportunities. Whenever the parole officer functions in this enforcement role, the rapport for which he has worked is jeopardized. Parolees may react by regression in attitude and behavior toward the officer. This may create doubt in the thinking of the officer about the value of the clinic. Its services sometimes create a problem for a parolee who has a good job and who gets along without violating any other condition of parole except clinic attendance. The officer may come to view the psychotherapist as an authority figure. The patient may reinforce this idea out of resentment toward the psychotherapist, who believes that he must be unyielding about attendance at the clinic if psychotherapy is to take place.

This program raises many questions. Is the underlying psychiatric theory valid? Is it operationally useful to view most offenders as psychologically ill? If so, is psychotherapy really the method of choice for all the patients accepted by the clinic? Even if this is the case, what kind of coercive methods are appropriate? And are there certain offenders who require, in addition, environmental care and control not currently provided by parole supervision.*

There also is the problem of the psychic consequences for patients when they are required to be in group psychotherapy without adequate inner motivation. Are some precipitated into psychotic states or into defensive acting out by committing new crimes, thus removing themselves from further ego-disturbing pressures of treatment? Do some protect themselves from the psychotherapeutic process through shammed acquiescence? Perhaps those who do "protect" themselves in this way are the very ones who attend regularly, are compliant and praise the program—qualities that are viewed favorably by administration. On the other hand, the compliant patients may expect the therapist to "reward" them with not threatening their psychological defenses. In other words, are there patients who will comply with the requirement that they attend group therapy sessions in return for not becoming emotionally involved in the process? Discussion of these topics awaits further study.

In summing up, it may be well to recall the theoretical issues raised at the beginning of this paper to see how they can be viewed in terms of the data presented.

Through coercion, the actual physical presence of the patient in group psychotherapy sessions at the clinic has been obtained about 90 per cent of the time. In the first three years of the program absenteeism from scheduled psychotherapy sessions was about 25 per cent, but during the last year this has been reduced to 10 per cent through the development of improved enforcement procedures by field parole services. But attendance is only a means to the therapeutic goal; it is no guarantee of attainment of the goal.

Is forcing psychotherapy upon nonpsychotic patients in the community morally justified? This question arises from the human right to be what one wishes to be, and the measuring of this right against the rights for protection of the other persons who compose society.[10] The clinic, of course, is not the only treatment program under compulsion. An entire branch of psychiatry—the care of psychotic patients in hospitals—operates in part on this principle. The same is true of allied fields, such as social casework in authoritative settings.[9] Does the clinic's program really reflect a different theory? In view of past offenses and probability of recidivism, these criminal offenders, if left untreated, remain a social menace. What about their potential victims, the persons they might rob, murder or otherwise injure? The failure to treat would be an even more serious ethical problem.

Finally, the question need be faced, how effective with this population is group psychotherapy under coercion? No definitive answer can be given to this evaluative question at this stage of development. The program is quite new. Many administrative and personnel matters have to be resolved and procedures effected before one can assume that treatment is being given under the conditions which would constitute a fair test of the psychoanalytically oriented method with the personalities these criminal offenders have.

The clinic must be viewed first and foremost as a laboratory, where the State of California is providing psychiatry with an opportunity to demonstrate what it can contribute to parole. In the day-to-day process of work, the staff has many discouraging experiences which only occasionally are balanced by the kind of gratifications psychotherapists work for. But there is much satisfaction in the realization that

*The question of what might be done to improve the effectiveness of this program is beyond the scope of this paper; it involves a comparative assessment of a great variety of ideas in which different people in the field have confidence. The ideas include more intensive and longer term psychotherapy, release through a "half-way house," more social case work, and more intensive parole supervision.

once the present program can be perfected and subjected to an evaluative research, it promises to add to psychiatry's capacity to be of service.

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